# Long Term Care Highlights

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North Dakota Department of Health
Division of Health Facilities

Inside this issue:



## Management of Tube Feedings

By Patricia Swenson, R.N., Health Facilities Surveyor

Federal tags F321 and F322 address naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that "A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable"; (F321) and "A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills." (F322) F321 also is intended to prevent the use of tube feeding when ordered over the objection of the resident. Decisions about the appropriateness of tube feeding for a resident are developed with the resident or his/her family, surrogate or representative as part of determining the care plan. Complications in tube feeding are not necessarily the result of improper care, but assessment for the potential for complications and care and treatment are provided to prevent complications in tube feeding by the facility.

The American Society for Parenteral and Enteral Nutrition (ASPEN) guidelines recommend enteral nutrition for patients who are or will become malnourished and who are unable to maintain their nutritional status through oral feedings. However, patients must have a functional gastrointestinal (GI) tract, and if they need tube feedings for longer than three to four weeks, a long-term feeding tube must be considered.

The most commonly used tubes are named for the positions of their feeding tips. For instance, those positioned in the stomach are gastrostomy tubes and those in the jejunum are jejunostomy tubes. Beyond the tip location, nurses should know the size, material and brand of any tube that has been placed in their patients, as well as who inserted it.

*Management of Tube Feedings (continued)*

Vigilant nursing care can prevent the most common mechanical complications: tube displacement, exit site problems, tube injury, and tube clogging.

Tube displacement can occur when the tube slides in or is pulled out of the GI tract. If the tube slides into the GI tract, the internal end can block the gastric outlet, causing nausea and vomiting. Tube displacement can be prevented through a combination of measures including documenting and verifying the external length, assessing the residual tube fluid and securing the tube with any number of tube-anchoring devices available on the market. Feeding tubes that fall out must be replaced within a few hours.

Exit site problems can be lessened by stabilizing the tube and by frequently inspecting the skin surrounding the exit site for redness, tenderness, swelling, purulent drainage or enteral leakage.

Tube occlusion or clogging is one of the most common mechanical complications of enteral nutrition. Occlusions can be caused by inappropriate administration of medications, poor flushing techniques, thick formulas, or reflux of gastric or intestinal contents into the tube. If an occlusion does occur, immediate attention to the clog is important. Water is the best flush solution. Flushing with 30 ml of water before and after checking for residuals, administering medications, or intermittent feedings, and every four to six hours is ideal for preventing tube occlusion.

General rules and written guidelines for medication administration can provide nursing staff with clear steps to take to avoid tube occlusion and optimize a therapeutic response to medications. These general rules include:

- Use the oral route if at all possible. If a tube must be used, use liquid medications.

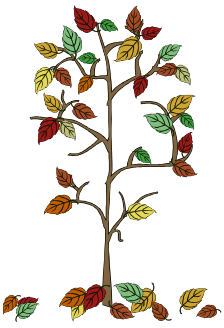
- Flush before and after medication administration with 30 ml of water.
- Dilute liquid medications with at least 30 ml of water to reduce osmolality.
- If liquid medications are not available, check to see that the tablet medication can be crushed.
- Administer each medication separately to avoid drug-drug interactions, and flush well between doses with 10ml to 15 ml of water. Avoid mixing any medications with the feeding formula to avoid drug-nutrient interactions.
- Consider the timing of the medication, and check whether it should be given on an empty or full stomach. Provide the exact placement location information to the dispensing pharmacist to provide the correct dosage form.

Complication prevention and quick knowledgeable nursing intervention will provide a positive tube feeding experience for patients requiring enteral nutrition. Tube feeding care requires research-based guidelines and incorporation of those guidelines into nursing practice for the safe, effective delivery of enteral nutrition.

Reference:

1 Mechanical Complications in Long-Term Feeding Tubes; Nursing Spectrum; Peggi Guenter, RN, nsweb.nursing spectrum.com.

2 Guidance to Surveyors – Long Term Care Facilities.



Additional Information Regarding Management of Tube Feedings

Many drugs, when mixed with enteral products, cause thickening or clumping which can lead to blockages in the feeding tubes. These include:

- Tagamet
- Dimetapp
- Feosol Elixir
- Robitussin syrup
- Riopan
- Reglan syrup
- Potassium Chloride (some liquid forms)
- Melleril
- Zinc Sulfate

In addition, the presence of enteral formulas may affect the bioavailability of some drugs including tetracycline, Dilantin, methyldopa and theophylline.

Reference: Pronsky, Zaneta, Food Medication Interactions, 2000, 11th edition, p. 324

## Hypoglycemia in the Non-Diabetic Elderly

By Laura L Hiebert, M.S., L.R.D., Health Facilities Surveyor

Chronic hypoglycemia can more than double a resident's risk of mortality. Long term care professionals in nursing and dietary often work together to minimize the risks of hypoglycemia in their diabetic patients.

According to a 1998 study by Shilo et.al., long term care staff should be paying more attention to their non-diabetic patients. Sixty percent of the elderly, non-diabetic hospital patients followed in this study had hypoglycemia. The mean blood sugar for this group was $39.9 \pm 7$ mg/dl.

Symptoms were not present in one-third of the patients with low blood sugar. When hypoglycemia develops over a period of time, as is often the case in the elderly, patients don't exhibit the common symptoms of hypoglycemia (sweating, weakness, hunger and tachycardia). A slow drop in blood sugar tends to have a greater effect on the brain.

When assessing potential hypoglycemia in a non-diabetic patient, one should look for headaches, blurred or double vision, incoherent speech and mental confusion. If the hyperglycemia persists, one may see sensory or motor deficits. Permanent brain damage, convulsions, coma and death are also possible outcomes of prolonged hyperglycemia.

Some of the risk factors for hypoglycemia include cancer, congestive heart failure, liver disease, sepsis, renal insufficiency and low serum albumin levels. Residents with poor intakes and those who are taking oral hypoglycemics are also at risk.

To decrease the possibility of hypoglycemia in your residents, try offering several small meals throughout the day. Be sure to offer adequate protein. Carbohydrates not eaten at meals should be replaced. Grape juice is rich in carbohydrates and is usually well accepted by residents.

References:
Shiol, Samuel, et. al., 1998, Hypoglycemia in Hospitalized Nondiabetic Older persons, Journal of the American Geriatric Society, Vol 46, pp. 978-982.
Zeman, Frances, 1991, Clinical Nutrition and Dietetics, p. 458.

## Nursing Facility Guideline for RN Waiver Request

By Bruce Pritschet, Long Term Care Manager, Division of Health Facilities; and Carolyn Desper, R.N., Health Facilities Surveyor

In the past few months, our office has repeatedly been asked to provide and explain the skilled nursing home waiver licensing requirements for registered nurses. These inquires are regarding the requirement at 33-07-03.2-14 Nursing Services. 3 (a) "At least one registered nurse on duty for at least 8 consecutive hours a day, 7 days a week."

Below you will find a description of what information is necessary for the survey agency to determine if the skilled nursing facility is eligible for a licensing waiver to the RN requirements. If your facility is interested in applying for an RN waiver, all documentation identified below must be submitted to the Division of Health Facilities for review. It will be necessary to obtain final waiver approval for the Medicare/Medicaid certification by the Centers for Medicare & Medicaid Services (CMS) at the Denver Regional Office.

A. Evidence of recruitment efforts:

1. Facility must be located in a Health Professional Shortage Area (HPSA) where hiring and retaining RNs would be considered difficult.
2. The facility must submit copies of advertisements indicating the RN opening(s) and that the position has been advertised for at least 90 days.
3. Submit copies of salary and benefits offered at the facility and how they compare to the salaries and benefits of facilities in the surrounding area.
4. Include copies of responses to ads if any were received.
5. Submit an explanation of why any applicant(s) were not offered employment or why the applicant(s) declined employment.

B. Evidence the Board of Nursing was contacted and asked to supply information on RNs.

1. Facility should show evidence of obtaining a listing of registered nurses in the area from the Board of Nursing and documentation of the contact made to each of the registered nurses identified on the listing.
2. Include reasons why the RN position was not offered or why the applicant declined the RN position as offered.

C. Prior to receiving a waiver , the facility must:

1. Inform the physician of each resident/patient in the facility of the request for an RN waiver.
2. The physician of each resident/patient must verify the resident/patient does not require RN services be provided directly on site by an RN as defined by rule and/or regulation.
3. Each resident's/patient's medical record must reflect the physician's verification that RN services are not necessary, for up to a 48-hour period, to maintain the health and safety of the resident/patient.
4. Submit actual staffing levels for RNs in the past three months and include resident/patient acuity levels for the same three-month period.
5. Submit proposed staffing pattern for a three-month period indicating the periods where an RN will not be available as defined in the applicable rule/regulation.

D. If the RN waiver is granted, the facility must:

1. Inform the current residents/patients and their legal representatives and families of the waiver.
2. Notify the state ombudsman and local ombudsman of the RN waiver.

3. Notify the adult protection and advocacy (P&A) and inform them of the RN waiver.
4. Provide the RN waiver information to all individuals seeking admission to the facility.
5. Publish a notice in the local paper that states the conditions of the RN waiver and the waiver's coverage time period.
6. Have an RN and/or a physician who is obligated to respond immediately to calls, on site if indicated, from the facility.
7. If the RN waiver is granted, the waiver period will not exceed the period of facility licensure. If the facility has not alleviated the need for an RN waiver at the end of the licensure period, an additional waiver may be granted one time for a specific period of time not to exceed one year and shall expire on December 31 of the year issued.
8. The facility will be required to repeat the process of application for each licensure period.

E. Facilities with an RN waiver are not eligible to operate an approved nurse aide-training program.

1. If the facility has an approved nurse aide training program (NATP) or a nurse aide training and competency evaluation program (NATCEP), the program approval is withdrawn on the date the RN waiver is granted.
2. The facility is not allowed to operate a nurse aide training program while an RN waiver is in place at their facility.
3. The facility is denied approval of a NATP or NATCEP for two years from the date the RN waiver is removed (no longer needed).

## RAI Update

By Pat Rotenberger, State RAI Coordinator

The Centers for Medicare & Medicaid Services (CMS) distributed a draft copy of the revised Long Term Care Resident Assessment Instrument (RAI) User's Manual to all state RAI coordinators at its conference August 6 through 8, 2002. The state RAI coordinators have until Sept. 9, 2002 to submit their comments. CMS plans to have this revised manual on its website by the end of September 2002.

The revised Long Term Care RAI User's Manual incorporates all of the questions and answers CMS has issued in the past several years. The answers are called clarifications. CMS also incorporated the information for the Swing Bed Minimum Data Set (MDS) and the Medicare Prospective Payment System Form (MPAF) into this revised manual.

Due to our case mix method of determining payment in North Dakota, the MPAF can only be completed for residents who are receiving Medicare. As soon as the revised manual is finalized, a Basic RAI workshop will be scheduled.

If you have any questions about this information, please contact Pat Rotenberger, state RAI coordinator, at 701.328.2352 or e-mail at protenbe@state.nd.us.

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